STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 122080-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this ____ day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 28, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health care benefits under a plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). His health care benefits are defined in BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 15, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner was prescribed a sleep apnea mouth appliance to reduce upper airway collapsibility. On December 2, 2010, XXXXX, D.M.D., fabricated the device. Dr. XXXXX does not participate with the BCBSM network of providers. The amount charged for this care

was $2,100 and BCBSM paid $859.06. The Petitioner appealed BCBSM's amount paid. BCBSM held a managerial-level conference and issued its final adverse determination dated June 14, 2011, affirming its claims decision.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's sleep apnea device and related care?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that BCBSM's reimbursement is insufficient because it did not take into account the four appointments needed to prepare the device and ensure a proper fit. This would include the initial diagnosis, taking of impressions and follow-up appointments. He believes BCBSM should pay more since, according to the laboratory that fabricated the appliance, BCBSM's payment doesn't even cover the cost of the appliance. He also believes BCBSM is claiming incorrect codes were submitted as a way to get out of paying.

BCBSM's Argument

In its final adverse determination, BCBSM explained its claim processing:

> You are covered by the *Community Blue Group Benefits Certificate.* Page 4.2 explains that we pay our "approved amount", less your cost sharing (deductible and/or copayment) requirements for covered professional services. Page 5.2 explains that we pay up to our "approved amount" for the rental or purchase of covered durable medical equipment. The same certificate further explains that the "approved amount" is the lesser of the billed charges or the maximum payment level for the service reported.
>
> In this case, Dr. XXXXX reported procedure E0486 (oral device/appliance used to reduce upper airway collapsibility, custom fabricated, includes fitting and adjustment) and 99245 (office consultation, 80 minutes). Our maximum payment level for procedure E0486 was $859.06 at the time of your service. Furthermore, consultation codes (99245) are no longer accepted. Such services are now considered when reported with the appropriate office visit procedure code. Thus, no payment is currently warranted for these services.
>
> Please know that if we receive a new claim from Dr. XXXXX to report more appropriate procedures, we can reconsider our position at that time. . . .

> Please also know that Dr. XXXXX is a nonparticipating provider. Therefore, you can be billed for the charges reported. Page 4.33 of your certificate explains that you will need to pay most of the charges yourself when services are provided by a nonparticipating provider. Nonparticipating providers do not have an agreement with us to accept our maximum payment level as payment in full.

Commissioner's Review

BCBSM's approved amount is the amount paid for claims from both participating and nonparticipating providers. There is nothing in the certificate that requires BCBSM to pay more than its approved amount, even in an emergency or even if there are no participating providers available. The certificate also does not require BCBSM to pay a nonparticipating provider's charge in full under any circumstances. The certificate provision on page 4.33, referenced by BCBSM, states:

> **HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**
>
> **Nonpanel Providers**
>
> *** * ***
>
> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to the subscriber.
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

Thus, the Petitioner may be responsible for the balance of the dentist's fee above BCBSM's approved amount. BCBSM determined that the approved amount for the Petitioner's appliance was $859.06. If Dr. XXXXX had been a BCBSM panel provider, she would have accepted the approved amount as payment in full. BCBSM is not required under the terms of the Petitioner's coverage to pay any additional amount for his care.

The Commissioner finds that the Petitioner's claims in this case were processed correctly according to the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 14, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's sleep apnea device and related care.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner